Medicaid Planning
Consult Information Sheet
(Single)

Date of Interview: ____________________
Location: ______ **Boynton Ofc.** **Other:** ________________
Others Present: ____

CLIENT - GENERAL INFORMATION

1	**Gender**	_____ **Male** ______ **Female**
2	**Salutation**	_____ **Mr.** ____ **Mrs.** ______ **Ms** ________ **Dr.**
3	**Full Name**	
4	**Home Address**	
5	**City, State, Zip**	
6	**County**	
7	**Home Phone**	
8	**Cell Phone**	
9	**Work Phone**	
10	**Email**	
11	**Citizenship**	______ U.S. Citizen & Resident ____ U.S. Resident ______ Other ________________

CLIENT - DETAILED INFO

12	**Soc Sec Number**	(Optional)
13	**DOB**	
14	**Age**	

15	**Client Veteran or Spouse of a Veteran**	______ Yes ______ No

16	**How did you learn about us**	____ Referred _____ Internet ____ Facebook ____ GG law firm website ____ Print Ad _____ Direct Mail
17	**If you were referred, who referred you**	

CLIENT – MARITAL HISTORY

18	**Client Marital Status**	_____ **Widow** _____ **Never Married** _____ **Divorced** **Date of Divorce:** _______________ **Paying Alimony:** ____________
19	**Children** **Yes** _____ **No** _____	**Child Full Name – Age - City/State. Note if Disabled:** 1. ________________________________ ______ ____________________ [ ] Disabled 2. ________________________________ ______ ____________________ [ ] Disabled 3. ________________________________ ______ ____________________ [ ] Disabled 4. ________________________________ ______ ____________________ [ ] Disabled

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CLIENT REP

	Client Rep	
20	Client Rep Acronym	
21	Client Rep Full Name	
22	Client Rep Relation	_____ Spouse _____ Child _____ Relative ____ Other
23	Client Rep Address	
24	Client Rep City State	
25	Client Rep Zip Code	
26	Client Rep Cell Phone	
27	Client Rep Home Phone	
28	Client Rep Email	

CLIENT - CURRENT ESTATE PLANNING DOCUMENTS

29	**Client Current Will?**	Yes______ No _____ If yes, date: ________________ STATE: ______________ Comments: ____
30	**Client Have any Trusts?**	Yes______ No _____ If Yes, Date_________________ STATE: ______________ Comments: ____
31	**Client Have Durable Power of Attorney?**	Yes______ No______ If Yes, Date_________________ STATE: ______________ Comments: ____
32	**Client Have Health Care Directive?**	Yes______ No ______ If Yes, Date ______________ STATE: ________________ Comments: ____
33	**Client Have Living Will?**	Yes _____ No ______ If Yes Date _______________ STATE: ________________ Withhold Nutrition: Yes: ________ No: ________

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CLIENT HEALTH INSURANCE

	Client - Health Insurance	
34	Client Have Medicare Coverage	______ Yes _____ No If yes: _______ Traditional Medicare ______ Managed Care or PPO
35	Client Have Medicare Supplement Insurance?	Medicare Supplement Insurance _____ Yes _____ No If Yes: Company:_________________________ Monthly Premium: ________ Medicare Part D Coverage _____ Yes ____ No If Yes, Company: _________________________ Monthly Premium: $__________
36	Client LTC Insurance?	______ Yes ____ No

CLIENT CURRENT LOCATION AND HEALTH INSURANCE

37	Type of Living Arrangement	_____ Home _______ Hospital _____ ALF ______ Nursing Home ______ Other
38	Client Location Name and Address (If not home)	
39	Phone	
40	If in Nursing home or Hospital Date of admission	
41	If in Nursing Home, ALF or Hospital – Fund Source	_____ Self-Pay _____ Health Insurance _____ Medicare _____ Medicaid

CLIENT ADL'S (ACTIVITIES OF DAILY LIVING)

42	Client's Doctor Doctor Address/Phone	
43	Walk and Stand	Independent Requires Some Assistance Totally Dependent
44	Feed Self	Independent Requires Some Assistance Totally Dependent
45	Dressing Self	Independent Requires Some Assistance Totally Dependent
46	Bath Self	Independent Requires Some Assistance Totally Dependent
47	Toiletry	Independent Requires Some Assistance Totally Dependent
48	Continence	Independent Requires Some Assistance Totally Dependent
49	Transfer	Independent Requires Some Assistance Totally Dependent
50	Dementia Diagnosis	_____ No _____ Yes Diagnosis_______________________________
51	General Overall Health	

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LISTING OF ASSETS

(CONFIDENTIAL)

List all of the assets owned with current balance. It is important to be as accurate as possible. Include all bank checking, savings, and money market accounts, brokerage accounts, CD's, Bonds, Annuities, Life Insurance – Current Cash Surrender Value, Retirement Accounts current value.

Asset (In Dollars)	Client ($$)	Joint (w/ Others - $$)	Comments
Primary Residence			**Purchase Date:** **Price:**
1st Mortgage			**Orig Amount:** **Balance:**
Additional Residence			**Purchase Date:** **Price:**
1st Mortgage			**Orig Amount:** **Balance:**
Auto 1 **Make**______________ **Model:** ____________ **Year:**			**Mileage**
Owed on Auto 1			
Auto 2 **Make**______________ **Model:** ____________ **Year:**			**Mileage**
Owed on car			
Bank Acct			
Bank Acct			
Bank Acct			
Bank Acct			
Life Insurance			
CD 1			
CD 2			
IRA 1 (Current Value)			
IRA 2 (Current Value)			
401(k) (Current Value)			
Cemetery Plot			
Funeral Plans			
Annuity Value			
Bonds			
Bus Assets/Rental Prop			
TOTALS			

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GROSS MONTHLY INCOME

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List all sources of income. Be sure to list the Gross Monthly Income (Amount before any deductions).

Source	Client (Monthly Gross $$)	TOTAL
GROSS Social Security (Retirement)		
IRA (Traditional) – Distributions		
GROSS Pension Amount		
Interest		
Dividends		
Gross Wages		
Gross Total Income		

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Cash Flow Analysis MONTHLY	
	TOTAL
TOTAL MONTHLY GROSS INCOME (All Sources)	
SHELTER COSTS	
Mortgage Payment	
Property Taxes	
Home Insurance	
Condo/Assoc. Dues	
Electric	
Water/Sewer	
Cable TV	
Telephone	
Other: ____________________	
Other:_____________________	
Total Shelter Costs	
OTHER EXPENSES	
Food	
Entertainment	
Auto Payment	
Auto Insurance	
Gasoline	
Credit Card Pmts	
Other: ____________________	
Other: ____________________	
Other ____________________	
Total Other Expenses	
HEALTH CARE COSTS	
Medicare Part B Premium	
Medicare Part D Premium	
Health Insurance Supplement	
Care Managers/Nurse Services	
Co-Pays and Deductibles	
Other: ___________________	
Other:___________________	
Total Health Care Costs	
Other: ___________________	
Other: ___________________	
GRAND TOTAL EXPENSES	
NET CASH FLOW	
Income taxes Paid - Last year	
Other Taxes:_______________	
Other: ________________	

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TRANSFERS, GIFTS, OR SALES OF IN LAST 60 MONTHS

(Include any transfers from accounts held jointly with others)

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Asset Transferred or Sold	Date Transferred	Amount	To Who/Where

DEBTS

(CONFIDENTIAL)

Type of Debt	Date Transferred	Amount	To Who/Where
Credit Card 1 - ____________________			
Credit Card 2 - _____________________			
Credit Card 3 - _____________________			

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COMMENTS/NOTES

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